Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

December 22, 2014

Mr. Mike Nichols, Administrator
Pennington House
1822 North Ave
Burlington, VT 05408-1303

Dear Mr. Nichols:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on . Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0607	A. BUILDING: _____ B. WING _____	C 11/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENNINGTON HOUSE	1822 NORTH AVE BURLINGTON, VT 05408

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 11/25/14. The following regulatory violations were identified.	R100	Please see Attachment.	
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.11 Staff Services 5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following: (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the home failed to assure that 2 of 4 direct care staff	R179		

R179, R206, R213 + R227 POCs accepted 12/17/14 Stowe/Paine

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R179	Continued From page 1 reviewed had received all required training. Findings include: Per review of staff training records, there was no evidence that Residential Instructor (direct care staff) #3, whose date of hire was 8/25/14, and #4, whose date of hire was 7/21/14, had completed training related to the home's policies and procedures regarding mandatory reports of abuse, neglect and exploitation. The residence Manager confirmed, during interview on the afternoon of 11/25/14, that Residential Instructors #3 and #4 had not completed the required training.	R179		
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to report an incident of potential abuse to the appropriate State Agency in a timely manner. Findings include: Per record review the home failed to report an incident in which Resident #1 had his/her hands held by direct care staff while forced to take	R206		

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R206	Continued From page 2 medication that s/he had previously refused. In addition to holding the resident's hands, a staff member cupped the resident's mouth in a manner to prevent the resident from spitting the medication out. Although the incident occurred on 11/15/14 it was not reported to Adult Protective Services (APS) until 4 days later on 11/19/14. The residential Manager confirmed, during interview on the afternoon of 11/25/14, that the incident was not reported within the required 48 hour period.	R206		
R213 SS=D	VI. RESIDENTS' RIGHTS 6.1 Every resident shall be treated with consideration, respect and full recognition of the resident's dignity, individuality, and privacy. A home may not ask a resident to waive the resident's rights. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the home failed to assure that 1 resident was treated in a respectful and dignified manner during administration of medications. (Resident #1). Findings include: Per record review Resident #1 was treated in a disrespectful and undignified manner when s/he was restrained by staff in an effort to force him/her to take medications. Although Resident #1 had refused his/her medications on the morning of 11/15/14, Residential Instructor (direct care staff) #1 held the hands of the resident while Residential Instructor #2 administered the medication PO (by mouth). After administering the medication, one of the staff members cupped	R213		

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R213	Continued From page 3 the resident's mouth in a manner to attempt to prevent the resident from spitting the meds out. During individual interviews, on the afternoon of 11/25/14, both Residential Instructor #1 and Residential Instructor #2 stated that, on the morning of 11/15/14, Resident #1 had been displaying aggressive behavior, swinging his/her arms at staff, and had refused to take his/her medication. Each staff member stated that they were concerned that the resident's aggressive behavior would further escalate without the benefit of the medication, therefore the resident's hands had been gently held, for a period of approximately 30 seconds, to prevent staff from being hit while the medication was administered, and the resident's mouth had been cupped in a manner to attempt to prevent the resident from spitting the medication out.	R213		
R227 SS=D	VI. RESIDENTS' RIGHTS 6.15 Residents have the right to refuse care to the extent allowed by law. This includes the right to discharge himself or herself from the home. The home must fully inform the resident of the consequences of refusing care. If the resident makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a resident's needs increasing beyond what the home is licensed to provide, or will result in the home being in violation of these regulations, the home may issue the resident a thirty (30) day notice of discharge in accordance with section 5.3.a of these regulations.	R227		

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R227	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview staff failed to respect the resident's right to refuse treatment, including medication, for 1 of 3 residents reviewed. (Resident #1). Findings include: Per record review although Resident #1 had refused his/her medications on the morning of 11/15/14, Residential Instructor (direct care staff) #1 held the hands of the resident while Residential Instructor #2 administered the medication PO (by mouth). After administering the medication one of the staff members cupped the resident's mouth in a manner to attempt to prevent the resident from spitting the meds out. During individual interviews, on the afternoon of 11/25/14, both Residential Instructor #1 and Residential Instructor #2 stated that, on the morning of 11/15/14, Resident #1 had been displaying aggressive behavior, swinging his/her arms at staff and had refused to take his/her medication. Each staff member stated that they were concerned that the resident's aggressive behavior would further escalate without the benefit of the medication, therefore the resident's hands had been gently held, for a period of approximately 30 seconds, to prevent staff from being hit while the medication was administered, and the resident's mouth had been cupped in a manner to attempt to prevent the resident from spitting the medication out.	R227		

HowardCenter

102 SOUTH WINOOSKI AVENUE / BURLINGTON, VT 05401

T: 802.488.6500 / F: 802.488.6501

WWW.HOWAROCENTER.ORG

DEC 15 2014

Pamela M. Cota, RN
Licensing Chief
Division of Licensing and Protection
103 South Main Street, Ladd hall
Waterbury, VT 054671-2306

December 12, 2014

Dear Ms. Cota:

Listed below are the plans of correction for each deficiency cited in the complaint investigation at Pennington House, 1822 North Ave RCH of HowardCenter Developmental Services that took place on November 25, 2014.

R179 V. Resident Care and Home Services

1. Pennington House staff will be trained in the Pennington House Policies and Procedures regarding mandatory reporting of abuse, neglect and exploitation. Staff #3 and #4 have read and signed the Policy and Procedure around reporting abuse, neglect and exploitation. To ensure that deficient practices do not recur the Residential Manager for Pennington House, Michael Nichols, will review all mandatory Residential Care Home staff trainings, including APS reporting guidelines, on a monthly basis during staff supervision. Residential Manager will have staff sign a training record to indicate compliance and understanding of all trainings. Corrective action has been completed.

R206 V. Resident Care and Home Services

1. Pennington House Residential Manager, Michael Nichols, has reviewed the guidelines for reporting abuse, neglect, and exploitation within 48 hours of the incident to APS. To ensure that deficient practices do not recur the Residential Manager, Michael Nichols, will meet with the Residential Senior Leader, Christine Rainville, monthly to review the guidelines of reporting APS. Residential Manager will sign off on a training record to indicate his compliance and understanding of the guidelines. Corrective action has been completed.

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R213 VI. Residents' Rights
R227 VI. Residents' Rights

1. Pennington House Residential Instructor #1 and #2 will read the Resident Rights as outlined in the Residential Care Home Licensing Regulation sections 6.1 through 6.18. They will sign a training record indicating that they understand and will comply with the regulations. To ensure that deficient practices do not recur the Residential Manager for Pennington, Michael Nichols, will review section VI. Residents' Rights, of the Residential Care Home Licensing Regulations, with Pennington House Residential Instructors at the next Staff meeting. Residential Instructors will sign a training record indicating that they understand and comply with the entire Residents' Rights outlined in Section VI. Corrective action will be complete by December 18, 2014 for Residential Instructors #1 and #2. All Residential Instructors at Pennington House will complete review of section VI. by January 7, 2015.

Please feel free to contact me with any questions or comments.

Sincerely,

Christine Rainville
Senior Leader, Pennington House
HowardCenter
102 South Winooski Ave
Burlington, VT 05401
(802) 488-6515
christener@howardcenter.org